

NAMIC Group Insurance Trust
Request for Employee Benefits Proposal / Company Election Form

General Information

Requested Effective Date for Coverage to Begin _____
 (Coverage would not be provided retroactively)

Employer's Legal Name _____

Billing Address _____
 _____ City _____ State _____ Zip _____

Mailing Address _____
 _____ City _____ State _____ Zip _____

Telephone Number () _____ FAX Number () _____

Name/Title of Contact Person _____

Email Address of Contact Person _____

Is your company a member of NAMIC ? () Yes () No

Eligibility Information

Total Number of Employees on Payroll: _____

Total Number of Permanent *Full Time* * Employees: _____ *Full-Time employees must work a minimum 20 hours per week

Number of Directors who are not Active Employees _____

<u>Number of Employees Currently Enrolled</u>	<u>Employer Contributions</u>
_____ Group Life/AD&D	_____ % Group Life/AD&D
_____ Supplementary Life Insurance	_____ % Supplemental Life Insurance
_____ Supplementary Accidental Death & Dismemberment	_____ % Supplemental Accidental Death & Dismemberment
_____ Long Term Disability	_____ % Long Term Disability
_____ Short Term Disability	_____ % Short Term Disability
Dental Insurance: _____ High Plan _____ Low Plan	_____ % Dental Insurance
_____ Vision Insurance	_____ % Vision Insurance

Benefits waiting period for new employees is the completion of:
 () 30 Days () 60 Days () 90 Days () 180 Days () 365 Days

Continuation

Are any former employees and/or dependents eligible for coverage through COBRA for dental or vision? () Yes () No
 If yes, please identify by name. Attach separate sheet if necessary.

To the best of your knowledge, are any employees or dependents proposed for coverage disabled or unable to work because of a current or approaching hospital confinement, leave of absence or otherwise incapacitated? () Yes () No
 If yes, please provide the person's name and current status.

Please indicate all options below for which you would like a quote(s):

Group life/AD&D Insurance *

Fixed Amounts () \$10,000 () \$15,000 () \$20,000 () \$25,000 () \$50,000

Salary Option () 1 X Salary () 1.5 X Salary () 2 X Salary () 2.5 X Salary () 3 X Salary

*Employers must pay 100% of the premium to be eligible for pricing quoted.

Supplementary Life Options

These products may be either employer paid or employer/employee shared payment:

Supplemental Life () Dependent Life () Supplemental AD&D ()

Long Term Disability Insurance (LTD)

Elimination Period () 90 Days () 180 Days

Benefit Schedule () 50% () 66.67%

Benefit Payment () \$8,000 Monthly Maximum () \$10,000 Monthly Maximum

Funding () Employer-Paid () Employee/Shared Payment

Short Term Disability Insurance (STD)

Elimination Period (Sickness/Injury) () 7 Days () 30 Days

Benefit Period () 13 Weeks () 26 Weeks

Benefit Schedule () 66.67%

Benefit Payment () \$300 Weekly Maximum () \$2,000 Weekly Maximum

Funding () Employer-Paid () Employee/Shared Payment

Dental Insurance

High Option () Low Option () No Dental ()

Groups can offer both a high and a low dental plan to all employees

Vision Insurance

Vision () No Vision ()

Company Election Form

*NAMIC reserves the right to perform employer audits to ensure employers are paying the entire cost of any coverage elected as "100% employer paid".

As confirmation of acceptance of quote, please initial by each plan election being made and sign below.

Company Officer Approval: _____

Date: _____

Return this form by mail or fax to the attention of Edwina Payton at:

**NAMIC Group Insurance Trust
PO Box 68700, Indianapolis, IN 46268-0070
Fax: 317-872-5636 Phone: 800-336-2642**

Thank you for considering NAMIC for your Group Trust benefit needs! Would you take a moment to tell us why you chose NAMIC?